Workers' Compensation/Occupational Health
National Trends Study

Executive Summary

Prepared by:
Beryl Schulman, PhD
&
Sheryl Schwartz, MPA

with assistance from
Peg Boyle, JD, MPH

University of Washington
Department of Health Services

For the Washington State Department of Labor and Industries

June, 1997

Workers' Compensation / Occupational Health National Trends Study

EXECUTIVE SUMMARY

I. Introduction

Under contract with the Washington State Department of Labor and Industries (L&I), researchers at the University of Washington (UW) Department of Health Services conducted the National Trends Study. The goal of the study was to describe innovative approaches to health care delivery for injured workers which:

- are occupational health focused (i.e., use specific physician networks and protocols developed for workers' compensation coverage, and emphasize return to work, safety, and prevention)
- could be adapted to Washington state's workers' compensation regulatory environment.

The National Trends Study follows up on the recently completed Managed Care Pilot (MCP), in which L&I purchased medical services for injured workers through capitated managed care arrangements. The study is part of L&I's current investigation of ways it may implement the successful components of the MCP, without compromising State laws regarding workers' right to choose an attending physician. Information about innovative approaches nationwide is intended to provide L&I, business, and labor with ideas about program design options for Washington state.

II. Methodology

This study used key informant interviews to collect data about innovative workers' compensation health care delivery programs. Each interview focused on the following topics:

- structure of the service delivery system, including network composition
- impetus for and timing of program development
- primary prevention activities
- return to work activities
- approach to disability prevention, including management of complex cases
- handling of medical treatment disputes
- quality assurance mechanisms
- performance findings regarding quality, cost, satisfaction
- incentives and barriers to employee, employer, and provider participation
- policies regarding "opt out"
- policies and experience regarding out-of-network care
- most and least effective features of the program
- recommendations regarding development of successful programs

Telephone interviews were conducted with one* representative from each of 26 organizations. Each interview lasted about an hour. The range of the organizations investigated is as follows:

- 6 representatives from state agencies
- 5 union representatives (2 from the same organization, and 2 not connected with particular health care delivery programs)
- 2 representatives of university medical center-based programs
- 10 representatives of multi-state health care programs
- 3 representatives of single state health care programs
- 1 representative of a management consulting firm**.**

III. Findings

The information collected through the key informant interviews is highlighted briefly below. The complete findings are summarized by topic, in the body of this report, and by organization surveyed, in Tables 1-5 of Appendix C.

A. Provider Panels

- Most programs use a broad range of providers as primary treating physicians.
- Typically programs are more concerned about providers having workers' compensation experience than about a particular type of board certification.
- The university/medical center-based programs emphasize use of occupational medicine physicians as primary treating physicians, while most other programs use a broader range of providers.
- There is no consistent picture with regard to chiropractors serving as primary treating physicians; this varies according to state regulations and the individual philosophies of the programs investigated.
- In terms of panel size, some informants associated smaller panels with higher quality, while other informants associated larger panels with higher customer satisfaction.

B. Impetus for Program Development

Informants reported that their programs were developed mainly out of an interest in one or more of the following:

- decreasing costs
- improving access to care
- enhancing quality of care

C. Focus on Injury Prevention

Most programs have one or more of the following types of primary injury prevention activities:

- on-site safety inspections
- tracking of injury/illness trends to identify safety concerns
- on-site safety training
- general health promotion activities
- preventive education for employees

* Two representatives of one organization participated in one of the 26 interviews.

- employer incentives to develop safety programs

Representatives of organizations without primary injury prevention activities cited cost and lack of incentives or mandates as reasons for not having a prevention component.

D. Return to Work

Nearly all the informants emphasized return to work as a number one priority. The activities they described to accomplish return to work fall within the following categories:

- development (with employers) of modified job duties
- active case management
- early medical intervention
- rehabilitation
- wage replacement

E. Disability Prevention

Many informants noted that return to work activities were also disability prevention activities. They emphasized the importance of:

- modified work duty
- early medical intervention
- immediate and intensive case management
- communicating an expectation of return to work from the beginning of treatment onward
- focusing on worker abilities, rather than on restrictions

In terms of "at risk" cases (defined as those with four to six weeks of time loss) most informants:

- emphasized the use of early, aggressive treatment and case management to prevent cases from becoming at risk;
- stated that duration of time loss does not trigger a different set of case management activities;
- reported that the case managers are usually nurses (some of whom have a background in occupational health).

F. Quality Assurance

- Over half of the programs surveyed use treatment protocols, usually both purchased and developed.
- Few programs have a medical director board certified in occupational medicine; being familiar with the realities of the workers' compensation system is considered more important.
- About half of the programs are accredited by NCQA, JCAHO, and/or URAC.[*]

[*] National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and/or the Utilization Review Accreditation Commission. See Appendix A for a list of these and other acronyms used in this report.

G. Employee Incentives/Barriers to Participation

- None of the programs use formal incentives to attract employees.
- In general, programs rely more on the power of high quality services and care to attract employees, including a strong "caring" message.
- Reported barriers to employee participation were factors limiting access and concerns about being treated by the "company doctor."

H. Employer Incentives/Barriers to Participation

- Opportunities for employers to direct care, lower costs, and increase employee productivity were seen as the primary incentives for employer participation.
- The following were cited as cost-saving, quality-enhancing components of programs that attracted employers: early intervention, return-to-work focus, medical management, case management, access to networks, and alternative dispute resolution processes.

According to informants, the following can act as barriers to employer participation:

- regulatory requirements and administrative work
- cost, where less expensive health care programs are available
- lack of perceived incentives
- fear of employee dissatisfaction with restricted choice
- insurance carrier opposition based on perceived loss of control over claims.

I. MCO/Provider Incentives/Barriers to Participation

- MCOs are attracted by the opportunities to generate new business and/or more income.
- Providers are attracted primarily by the potential for increasing patient volumes.
- Programs may also seek to attract providers with salaries; educational, training and research opportunities; support services (e.g., case management); and expedited payment systems.
- Informants reported no problems recruiting MCOs and providers, but noted that certification requirements, operating regulations (including paperwork), competition, potential for litigation, and lack of financial incentives may deter their participation.

J. Accessing Care Outside the Program

Circumstances under which employees can "opt out" of programs vary from state to state.

- In California, employees can designate an outside provider prior to being injured, or wait a specified number of days after the injury to see an outside provider.
- In New York, employees can opt out of employer-directed care after 30 days.
- After a first visit to a Healthcare First provider (in Massachusetts) an injured worker can go anywhere for care.

Common circumstances under which employees can access outside care while continuing to participate in the program are:

- in an emergency
- if the care needed is not conveniently available within the network
- if the employee has an existing relationship with a provider who agrees to abide by the MCO rules
- if the out of network care is acceptable in terms of quality and cost.

Very few informants reported problems with injured workers going out of network. In terms of discouraging out-of-network care, informants noted that injured workers might be responsible for bills or lose workers' compensation benefits if they received unauthorized outside care. However, more informants emphasized how high quality services and a sincere interest in injured workers encourages them to stay in network for care.

K. Program Evaluation

- Very few of the programs investigated have been formally evaluated, due to a lack of incentives, funds, and/or human resources.
- Those programs that tracked costs reported savings of 6-50%.
- A few programs noted an improved medical only to indemnity ratio (i.e., proportionally fewer time loss cases).
- Those programs that surveyed customer satisfaction reported largely positive outcomes.
- Several programs reported decreased litigation rates.
- Several programs reported a decreased number of lost work days.

L. Most Effective Aspects of Programs

When asked which aspects of their programs were particularly effective in improving care for injured workers, informants referred most frequently to:

- prompt access to appropriate levels of care
- early and on-going case management
- high quality providers
- focus on return to work
- partnerships/teamwork among stakeholders.

M. Least Effective Aspects of Programs

In general, informants had less to say about ineffective program components than about effective ones. Several informants commented that their programs were too new to assess this. Where program deficiencies were noted, they fell within the following areas:

- information systems
- prevention
- balancing costs and quality
- access to providers and services
- return to work
- state regulations and administrative complexities.

N. Informants' Recommendations

When asked how they would advise administrators interested in developing successful workers' compensation medical benefits programs, informants offered a wide range of recommendations. Some examples follow.

- Get input and buy-in from all customer groups.
- Think "outside the box."
- Emphasize prevention, early intervention, patient advocacy, and return to work.
- Select providers who care about injured workers and are willing to work with case managers in a structured health care delivery system.

- Have occupational medicine physicians responsible for diagnosis, treatment, case management, and return to work, even if they do not personally provide all the treatment.
- Pay providers fairly and create incentives for achievement of outcomes (e.g., lower indemnity costs/return to work).
- In order to achieve quality care and cost control, foster communication and collaboration among all involved parties.